

*If you are concerned that your child has a feeding problem, please complete this form by checking the boxes and review it with the doctor*



Child's name \_\_\_\_\_

Child's height \_\_\_\_\_ (cm)

Child's age \_\_\_\_\_

Child's weight \_\_\_\_\_ (kg)

Date \_\_\_\_\_

Child's head circumference \_\_\_\_\_ (cm)

**1. Does your child have any of the following symptoms? (check all the boxes  that apply)**

- a.  a. Choking or pain with swallowing
- b.  b. Weight loss
- c.  c. Vomiting
- d.  d. Diarrhea
- e.  e. Blood in stool
- f.  f. Food allergies
- g.  g. Eczema or hives
- h.  h. Asthma
- i.  i. Frequent infections
- j.  j. Delayed development

**2. Check the box next to the description that most sounds like your child**

- a. My child**
  - Gets hungry, readily begins eating but then pulls back and refuses to continue
- b. My child**
  - Eats a limited number of foods
  - Refuses foods because of smell, taste, texture, temperature and/or appearance
  - Only accepts foods prepared in a specific way
  - Is reluctant to try new foods

**My child has a poor appetite, and (check the box or boxes that best apply):**

- c. My child**
  - Was small at birth or premature
  - Has one or both parents who are small or grew slowly
  - Seems healthy and active
- d. My child**
  - Is not interested in food
  - Stops eating after a few bites
  - Constantly tries to get out of the high chair or to leave the table
  - Enjoys playing and interacting with familiar people
- e. My child**
  - Is withdrawn and irritable
  - Does not smile, babble, or talk much
  - Shows little interest in playing
- f. My child**
  - Cries at the sight of food or feeding device (eg, bottle, spoon, or high chair)
  - Is intensely resistant to feeding
  - Started refusing food after a frightening feeding experience such as choking or vomiting
  - Is or was tube-fed and fears eating

### 3. Please provide the following information:

Height of child's mother \_\_\_\_\_

Height of child's father \_\_\_\_\_

Was the child born premature?  Yes  No

If yes, how many weeks into the pregnancy was the child born? \_\_\_\_\_

Did either of the child's parents experience delayed puberty or slow growth as a child?  Yes  No

If yes, which parent? \_\_\_\_\_

### 4. Does your child eat:

Fruits?  Yes  No

If yes, which ones? \_\_\_\_\_

Vegetables?  Yes  No

If yes, which ones? \_\_\_\_\_

Meats or meat alternatives (e.g. tofu, soy beancurd, nuts, beans)?  Yes  No

If yes, which ones? \_\_\_\_\_

Dairy products? (e.g. milk, cheese, yogurt)

Yes  No

If yes, which ones? \_\_\_\_\_

Grains or other starchy foods?  Yes  No

If yes, which ones? \_\_\_\_\_

### Do Not Write In This Section—For Office Use Only

Weight-for-age percentile \_\_\_\_\_

Height-for-age percentile \_\_\_\_\_

Weight-for-height \_\_\_\_\_

Projected height at 20 years of age if child continues to grow along current height-for-age percentile:  
\_\_\_\_\_

### Midparental height calculations:

Boys:

( \_\_\_\_\_ + \_\_\_\_\_ ) ÷ 2 = \_\_\_\_\_

Dad's height (cm) Mom's height (cm) + 13

Girls:

( \_\_\_\_\_ + \_\_\_\_\_ ) ÷ 2 = \_\_\_\_\_

Dad's height (cm) - 13 Mom's height (cm)

Midparental height - Projected height at 20 years

= \_\_\_\_\_

Is difference >5 cm?  Yes  No